Triple P-Positive Parenting Program as a Public Health Approach to Strengthening Parenting

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Parenting programs have considerable potential to improve the mental health and well-being of children, improve family relationships, and benefit the community at large. However, traditional clinical models of service delivery reach relatively few parents. A public health approach is needed to ensure that more parents benefit and that a societal-level impact is achieved. The Triple P-Positive Parenting Program is a comprehensive, multilevel system of parenting intervention that combines within a single intervention universal and more targeted interventions for high-risk children and their parents. With Triple P, the overarching goal is to enhance the knowledge, skills, and confidence of parents at a whole-of-population level and, in turn, to reduce the prevalence rates of behavioral and emotional problems in children and adolescents. The distinguishing features of the intervention and variables that influence its effective implementation are discussed. Self-regulation is a unifying concept that is applied throughout the entire system (e.g., to interactions between children, parents, service providers, and agencies involved in delivering the intervention). Challenges and future directions for the development of public health approaches to parenting are discussed.

Keywords: parenting, prevention of behavior problems, public health

The quality of parenting that children receive has a major effect on their development. Evidence from behavior genetics research, as well as from epidemiological, correlational, and experimental studies, shows that parenting practices have a major influence on children's development (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Family risk factors, such as poor parenting, family conflict, and marriage breakdown, strongly influence children's risk of developing various forms of psychopathology. Specifically, a lack of a warm, positive relationship with parents; insecure attachment; harsh, inflexible, or inconsistent discipline practices; inadequate supervision of and involvement with children; marital conflict and breakdown; and parental psychopathology (particularly maternal depression) increase the risk that children will develop major behavioral and emotional problems (Coie, 1996; Loeber & Farrington, 1998).

There is substantial evidence that parenting programs based on social learning models (Patterson, 1982; Taylor & Biglan, 1998) are effective, particularly in the management of early onset conduct problems (Serketich & Dumas, 1996). However, they reach relatively few parents, and, consequently, many children continue to develop potentially preventable problems (Biglan, 1995).

This article describes the development and dissemination of a public health model of parenting intervention known as the Triple P-Positive Parenting Program (Sanders, 1999). This system of intervention is used to illustrate the tasks and challenges involved in developing, evaluating, and disseminating a public health approach to the delivery of parenting programs.

What is the Triple P-Positive Parenting Program?

Triple P was developed at the University of Queensland in Australia as a multilevel system of parenting intervention designed to improve the quality of parenting advice available to parents (Sanders, 1999; Sanders, Markie-Dadds, & Turner, 2003). The program began on a small scale as a home-based, individually administered training program for parents of disruptive preschool children (Sanders & Glynn, 1981). It has evolved over the past 25 years into a comprehensive public health model of intervention. Although individual parent training is very useful with families, it makes little impact at a population level. Inspired by examples of large-scale health promotion studies at the Center for Disease Prevention at Stanford University that targeted behaviors such as smoking, sedentary lifestyle, and unhealthy diet (Farquhar et al., 1985) and by concepts such as the need to design "living environments" for children (Risley, Clark, & Cataldo, 1976), Matthew R. Sanders and colleagues took the next 25 years to evolve an evidence-based system that could be successfully disseminated (Sanders, Cann, & Markie-Dadds, 2003). This process involved development of a range of brief and more cost effective interventions (e.g., Turner & Sanders, 2006a), more economical ways of delivering programs through groups (Zubrick et al., 2005), and more flexible delivery via telephone consultation (Con-

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nell, Sanders, & Markie-Dadds, 1997) and the media (Sanders & Prinz, in press), as well as use of epidemiological data to inform decisions about how to target parenting services (e.g., Sanders, Markie-Dadds, Rinaldis, Firman, & Baig, 2007).

The system aims to prevent severe behavioral, emotional, and developmental problems in children and adolescents by enhancing the knowledge, skills, and confidence of parents. It incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children from birth to age 16 (see Sanders, 1999, for an overview of Triple P). The suite of multilevel programs in Triple P is designed to create a "family friendly" environment that supports parents in the task of raising their children (see Table 1). It specifically targets the social contexts that influence parents on a day-to-day basis. These contexts include the mass media, primary health care services, child care and school systems, work sites, religious organizations, and the broader political system. The multilevel strategy is designed to maximize efficiency, contain costs, avoid waste and over-servicing, and ensure the program has wide reach in the community. Also, the multidisciplinary nature of the program involves increasing the skills of the existing workforce in the task of promoting competent parenting.

The program targets five different developmental periods from infancy to adolescence. Within each developmental period, the reach of the intervention varies from very broad (targeting an entire population) to quite narrow (targeting only high-risk children). This flexibility enables services and practitioners to determine the scope of the intervention, given their own service priorities and funding.

Self-Regulation: A Unifying Framework for Supporting Parents, Children, Service Providers, and Agencies

A central goal of Triple P is the development of an individual's capacity for self-regulation. This principle applies to all program participants, from parents to service providers and researchers. Self-regulation is a process whereby individuals are taught skills to change their own behavior and become independent problem solvers in a broader social environment that supports parenting and family relationships (Karoly, 1993). The self-regulation model draws heavily on Bandura's cognitive social learning theory (1977, 1986). In the case of parents who are learning to change their parenting practices, self-regulation is operationalized to include the following five aspects.

Promoting Self-Sufficiency

As all parenting programs are time limited, parents must become independent problem solvers who use their own resources and become less reliant on others in carrying out their parenting responsibilities. Self-sufficient parents are viewed as having the resilience, personal resources, knowledge, and skills they need to parent confidently, with minimal or no additional support.

Increasing Parental Self-Efficacy

Parental self-efficacy refers to a parent's belief that he or she can overcome or solve a specific parenting problem. Parents with high self-efficacy have more positive expectations that change is possible. Parents of children with behavior problems tend to have lower task-specific self-efficacy in managing their daily parenting responsibilities (Sanders & Woolley, 2005). A central goal of the intervention process is to foster greater confidence in daily parenting tasks.

Using Self-Management Tools

Self-management refers to the tools and skills that parents use to enable them to change their parenting practices and become self-sufficient. These skills include self-monitoring, self-determination of performance goals and standards, self-evaluation against some performance criterion, and self-selection of parenting strategies. As parents are responsible for the way they choose to raise their children, they select which aspects of their own and their child's behavior they wish to work on. They learn to set developmentally appropriate goals, choose specific parenting and child management techniques, and evaluate their success against self-determined criteria.

Promoting Personal Agency

The parent is encouraged to "own" the change process. This task involves encouraging parents to attribute changes or improvements in their family situation to their own or their child's efforts rather than to chance, age, maturational factors, or other uncontrollable events (e.g., spouse's poor parenting or genes).

Promoting Problem Solving

It is assumed that parents are active problem solvers and that the intervention must equip parents to define problems, formulate options, develop a parenting plan, execute the plan, evaluate the outcome, and revise the plan as required. However, the training process must assist parents to generalize their knowledge and skills, so they can apply principles and strategies to future problems, at different points in a child's development, and to other relevant siblings in a family.

These self-regulation skills can be taught to children by parents in developmentally appropriate ways. Attending and responding to child-initiated interactions and prompting, modeling, and reinforcing children's problem-solving behavior promote emotional self-regulation, independence, and problem solving in children. Self-regulation principles can be applied in training service providers to deliver different levels of the intervention (Turner & Sanders, 2006b), troubleshooting implementation difficulties, or addressing staffing problems within an organization (Sanders & Prinz, in press; Sanders & Turner, 2002).

Table 1
The Triple P Model of Parenting and Family Support

Level of intervention	Target population	Intervention methods	Practitioners
Level 1 Media-based parent information campaign Universal Triple P	All parents interested in information about parenting and promoting their child's development.	Coordinated media and health promotion campaign raising awareness of parent issues and encouraging participation in parenting programs. May involve electronic and print media (e.g., community service announcements, talk-back radio, newspaper and magazine editorials).	Typically coordinated by area media liaison officers or mental health or welfare staff.
Level 2 Health promotion strategy/brief selective intervention Selected Triple P Selected Teen Triple P	Parents interested in parenting education or with specific concerns about their child's development or behavior.	Health promotion information or specific advice for a discrete developmental issue or minor child behavior problem. May involve a group seminar process or brief (up to 20 min) telephone or face-to-face clinician contact.	Parent support during routine well-child health care (e.g., child and community health, education, allied health, and child care staff).
Level 3 Narrow-focus parent training Primary Care Triple P Primary Care Teen Triple P	Parents with specific concerns (as above) who require consultations or active skills training.	Brief program (about 80 min over 4 sessions) combining advice, rehearsal, and self-evaluation to teach parents to manage a discrete child problem behavior. May involve telephone or face-to-face clinician contact or group sessions.	Same as for Level 2.
Level 4 Broad-focus parent training Standard Triple P Group Triple P, Group Teen Triple P Self-Directed Triple P Self-Directed Teen Triple P	Parents who want intensive training in positive parenting skills. Typically, parents of children with behavior problems, such as aggressive or oppositional behavior.	Broad-focus program (about 10 hr over 8–10 sessions) focusing on parent–child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions.	Intensive parenting interventions (e.g., mental health and welfare staff, and other allied health and education professionals who regularly consult with parents about child behavior).
Stepping Stones Triple P	Families of preschool children with disabilities who have or are at risk of developing behavioral or emotional disorders.	A parallel 10-session, individually tailored program with a focus on disabilities. Sessions typically last 60–90 min (with the exception of 3 practice sessions, which last 40 min).	Same as above.
Level 5 Intensive family intervention modules Enhanced Triple P	Parents of children with behavior problems and concurrent family dysfunction (e.g., parental depression or stress) or conflict between partners.	Intensive individually tailored program with modules (sessions last 60–90 min) including practice sessions to enhance parenting skills, mood management and stress coping skills, and partner support skills.	Intensive family intervention work (e.g., mental health and welfare staff).
Pathways Triple P	Parents at risk of maltreating their children. Program targets anger management problems and other factors associated with abuse.	Modules include attribution retraining and anger management.	Same as above.

Principles of Positive Parenting

The five core positive parenting principles that form the basis of the program were selected to address specific risk and protective factors known to predict positive developmental and mental health outcomes in children. Table 2 shows how these principles are operationalized into a range of specific parenting skills (see Sanders, 1999, for a more complete overview).

Safe and Engaging Environment

Children of all ages need a safe, supervised, and therefore protective environment that provides opportunities for them to explore, experiment, and play. This principle is essential to promote healthy development and to prevent accidents and injuries in the home (Peterson & Saldana, 1996; Risley, Clark, & Cataldo, 1976).

Positive Learning Environment

Although this principle involves educating parents in their role as their child's first teacher, the program specifically teaches parents to respond positively and constructively to child-initiated interactions (e.g., requests for help, information, advice, and attention) through incidental teaching and other techniques that assist children to learn to solve problems for themselves.

Assertive Discipline

Triple P teaches parents specific child management and behavior change strategies that are alternatives to coercive and ineffective discipline practices (such as shouting, threatening, or using physical punishment). These strategies include selecting ground rules for specific situations; discussing rules with children; giving clear, calm, age-appropriate instructions and requests; presenting logical consequences; using quiet time (nonexclusionary time-out) and time-out; and using planned ignoring.

Realistic Expectations

This principle involves exploring with parents their expectations, assumptions, and beliefs about the causes of children's behavior and choosing goals that are developmentally appropriate for the child and realistic for the parent. Parents who are at risk of abusing their child are more likely to have unrealistic expectations of children's capabilities (Azar & Rohrbeck, 1986).

Parental Self-Care

Parenting is affected by a range of factors that impact on a parent's self-esteem and sense of well-being. All levels of Triple P specifically address this issue by encouraging parents to view parenting as part of a larger context of personal self-care, resourcefulness, and well-being and by teaching practical parenting skills that both parents are able to implement.

Large-Scale Implementation of Positive Parenting

The translation of a multilevel program into a system of interventions delivered on a wide scale requires that several important tasks be accomplished so the public health approach can work. There are seven specific principles: (a) having evidence concerning the base prevalence rates of targeted child problems; (b) having evidence concerning the base prevalence rates of risk and protective factors; (c) having evidence that targeting such risk and protective factors reduces targeted child problems; (d) having evidence that effective and culturally appropriate interventions are available for dissemination; (e) having an effective system of training and dissemination; (f) making the interventions widely available; and (g) tracking outcomes at a population level. An additional requirement is a strategy for managing the sociopolitical environment that inevitably surrounds population-level interventions.

Establish Base Rates for Child Problems to Be Targeted

Information is required concerning the base rates of targeted behavioral and emotional problems in the areas targeted before the intervention begins. Epidemiological surveys show that approximately 14%–18% of Australian children develop significant mental health problems (Sawyer et al., 2000). When a criterion of parental concern about behavior or emotional problems is applied, the prevalence rates are even higher (Sanders et al., 2005). According to Sanders et al., 29% of 4,501 parents of 4- to 7-year-olds reported that their child had a behavioral or emotional problem in the previous 6 months and that they were concerned about both conduct problems and emotional problems.

Establish Base Rates for Modifiable Parental Risk and Protective Factors

Potentially modifiable parenting factors that place a child at risk of developing behavioral and emotional problems include exposure to a harsh, inconsistent parenting style, low parental self-efficacy in undertaking the tasks of raising children, mental health problems in parents (e.g., depression and anxiety), high marital or partner conflict and low levels of parenting support. Potentially modifiable protective factors that reduce children's risk of developing problems include exposure of parents to evidence-based parenting programs, access to professional support for children's emotional and behavioral problems, and high levels of social and emotional support from significant others. Epidemiological surveys show that large numbers of children are exposed to adverse parenting practices. For example, Sanders et al. (2007) found in a survey of 4,018 parents of 2- to 12-year-olds that 70% of parents reported they were likely or very likely to shout and become angry with their children and that 43% reported hitting their children. The risk and protective factors that are most likely to change as a result

Table 2
Core Parenting Skills Introduced in Triple P

| | Basic skills | | | | | Enhanced skills | | |
Parent–child relationship enhancement skills	Encouraging desirable behavior	Teaching new skills and behaviors	Managing misbehavior	Anticipating and planning	Self-regulation skills	Mood and coping skills	Partner support skills
Spending brief quality time	Giving descriptive praise	Setting a good example	Establishing ground rules	Planning and advanced preparation	Monitoring children's behavior	Catching unhelpful thoughts	Improving personal communication habits
Talking with children	Giving nonverbal attention	Using incidental teaching	Using directed discussion	Discussing ground rules for specific situations	Monitoring own behavior	Relaxing and managing stress	Giving and receiving constructive feedback
Showing affection	Providing engaging activities	Using ask, say, do	Using planned ignoring	Selecting engaging activities	Setting developmentally appropriate goals	Developing personal coping statements	Having casual conversations
		Using behavior charts	Giving clear, calm instructions	Providing incentives	Setting practice tasks	Challenging unhelpful thoughts	Supporting each other when problem behavior occurs
			Using logical consequences	Providing consequences	Self-evaluating strengths and weaknesses	Developing coping plans for high-risk situations	Solving problems
			Using quiet time	Holding follow-up discussions	Setting personal goals for change		Improving relationship happiness
			Using time-out				

of the intervention can be assessed prior to an intervention being implemented and can be reassessed over time.

Ensure That Interventions to Be Used Are Effective

Before an intervention is implemented widely, programs are required that have been demonstrated to be effective in changing risk and protective factors. There is sufficient good-quality evidence from randomized clinical trials to show that increasing positive parenting practices and reducing ineffective disciplinary practices produce better mental health and developmental outcomes in children than do comparison conditions, such as care as usual, no treatment, or wait list control conditions (e.g., Sanders, 1999; Taylor & Biglan, 1998).

According to the Society for Prevention Research (Flay et al., 2005), if a specific program is to be considered ready for broad dissemination, it must meet fairly stringent criteria for both efficacy and effectiveness. In addition, it should have the capacity to go to scale, have clear cost information available, and have monitoring and evaluation tools available for use by providers. A clear statement of factors that may affect sustainability of the program once it has been implemented should be available.

The cumulative evidence in support of the efficacy of Triple P has evolved over almost a 30-year period. It began with single-case experiments (e.g., Sanders & Glynn, 1981) and moved through a series of randomized efficacy and effectiveness trials that evaluated different levels of intervention and delivery modalities (e.g., Zubrick et al., 2005), studies examining the dissemination process, and, finally, evaluations at a population level (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2007; Turner, Nicholson, & Sanders, 2007). As a result, a considerable body of evidence has accrued that demonstrates the efficacy of various Triple P programs (see www.pfsc.uq.edu.au for a current list of all evaluation studies).

Ensure That Culturally Appropriate Programs Are Available

Parents from quite diverse cultural, linguistic, and religious backgrounds may seek support with parenting issues. A program needs to be both effective and culturally acceptable to parents. All parents learn how to parent in a specific cultural context that may vary in terms of family composition and structure, availability of extended family support, gender-based roles, and exposure to specific traditions and mores. Cultural knowledge about parenting is acquired through exposure to other members of the culture, conversations with more experienced parents, modeling, and family-of-origin experiences.

There are shared aspects of the parenting experience across different cultures. Parents in all cultures typically want their children to do well in life. Parents in different cultures experience similar developmental and behavioral problems as stressful, and there are gender differences in parental responsibilities. Parenting practices also vary within cultures and between cultures. A parent's culture informs a parent's belief about what is normal, age-appropriate behavior. It informs what is involved in being a parent and the kinds of responsibilities that are involved and which behaviors are problems that require discipline and the kind of discipline to use. There is increasing evidence that, despite differences between cultures, the fundamental principles of positive parenting are cross-culturally robust.

Triple P has been shown to be effective and acceptable to parents in a range of cultural contexts. These include trials with parents in Hong Kong (Leung, Sanders, Leung, Mak, & Lau, 2003), Japan (Matsumoto, Sofronoff, & Sanders, 2007), Germany (Heinrichs et al., 2006), Switzerland (Bodennman, Cina, Ledermann, & Sanders, 2008), Australia (Sanders, Markie-Dadds, Tully, & Bor, 2000), and New Zealand (Venning, Blampied, & France, 2003).

Adoption of a self-regulation framework when one is working with parents from diverse cultures enables parents to select meaningful and culturally relevant personal goals and goals for their children. This is not to suggest that cultural differences are unimportant. On the contrary, ethnic and cultural differences may influence whether parents participate at all in a parenting program, whether they consider a behavior a problem, and whether they consider different parenting and disciplinary methods acceptable. Strategies we have employed to ensure cultural relevance of Triple P include soliciting consumer opinion about the parental strategies advocated; conducting focus groups of elders, service providers, and parent consumers to identify key concerns and issues relevant to program implementation with specific ethnic groups; translating materials; reshooting video materials to ensure that indigenous families are included; using voice-synchronized dubbing of selected video material; and conducting outcome research with different ethnic groups to examine the efficacy of the culturally adapted procedures (e.g., Leung et al., 2003).

Have Program Resources Accessible

Quality materials are needed that can be made readily available to service providers. This principle means having "ready to use" resources that can be delivered to providers or parents as part of the intervention.

Provide an Effective Training and Dissemination Program

A multidisciplinary training program is needed that equips service providers with the content and process knowledge and skills they require to deliver different levels of the program with fidelity. See Turner and Sanders (2006b) for a description of the training process. We have conducted a number of studies that show the effectiveness of the training (e.g., Seng, Prinz, & Sanders, 2006).

The systems-contextual approach views the attitudes, knowledge, receptivity to innovation, and consulting practices of professionals as being embedded within the broader organizational environment within which the practitioner works (Biglan, Mrazek, & Carnine, 1999). Specifically, professional change is thought more likely to occur when

supervisors, managers, and professional colleagues support the adoption or change process (Backer, Liberman, & Kuehnel, 1986; Parcel, Perry, & Taylor, 1990); when peer supervision, feedback, and support are available (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997); and when computer technologies, such as the Web and e-mail services, are used to support and provide consultative backup to professionals. In organizations in which a culture of innovation is supported by management through the provision of resources and attention, a greater success in establishing and implementing new initiatives is predicted (Ash, 1997).

Make the Parenting Intervention Widely Available

When a program with universal elements exists, not all parents will participate. However, a starting point is to estimate the number of parents who must participate in universal aspects of the program if a population-level benefit is to be detected. In Every Family, a large-scale project that focused on the transition to school, we estimated the number of parents who needed to participate in a Triple P intervention to achieve a 5%, 10%, or 15% reduction of child behavioral or emotional problems at a population level. We used population prevalence rates from a baseline CATI (computer-assisted telephone interview) survey that indicated 23% of children were in the clinical range for emotional and behavioral problems. On the basis of effectiveness studies conducted as part of Every Family (Sanders et al., 2005), we estimated that approximately one third of parents would need to participate in the universal program if a 5% reduction in population prevalence rates of children's behavioral and emotional problems was to be achieved.

Once the minimum number of parents who need to participate has been determined, strategies are needed to optimize engagement. Parental willingness to participate in a parenting program depends on a number of factors, among them, the nature of the program offered, how it is delivered, perceptions of the parents as to whether the program is relevant and meets their needs, how much time they will need to invest in completing the program, and the payoff they anticipate relative to other uses of their time (Morawska & Sanders, 2006). A number of strategies, such as using the mass media to normalize and destigmatize participation, can be used to promote engagement. Television programs on parenting attract large viewing audiences, and there is some evidence that parenting practices improve when parents view others undergoing an evidence-based parenting program (Sanders, Calam, Durant, Liversidge, & Carmont, in press). The media can play an important role in raising parents' awareness and willingness to attend a parenting program. Different media messages can be used to demystify what is involved by providing relevant, meaningful, and accurate information for parents. Media messages also provide opportunities to depict parents' experiences of receiving professional support.

Another strategy is to develop variants that are tailored to the requirements of high-need groups. Although the basic Level 4 group program can be expected to meet the needs of the majority of parents, we have developed special variants for use when a group of parents has additional risk factors that need to be addressed. Examples of such tailoring include Stepping Stones Triple P, for parents who have a child with a disability (Sanders, Mazzucchelli, & Studman, 2004); Pathways Triple P, for parents at risk of maltreatment (Sanders et al., 2004); and Self-Directed Triple P, with telephone support, which was developed for rural families (Markie-Dadds & Sanders, 2006).

Use Strategies That Build Sustainability

A systems-contextual or ecological perspective is needed to ensure the sustainability of the intervention. The quality of the parenting intervention, the type of skills-training service providers receive, and the supportiveness of the post-training workplace environment interact to determine whether the service providers change the way they work with parents (Sanders & Turner, 2005). The dissemination method we employ uses a self-regulatory approach. To promote practitioner self-efficacy in use of Triple P, the program introduces content and processes through active skills training methods with a focus on self-directed learning, personal goal setting for skill development, self-evaluation, and problem solving. Professional behavior change is more likely when managers, administrators, and colleagues support the adoption of the innovation and when adequate supervision and support are available (Henggeler et al., 1997). Hence, an effective dissemination process must not only adequately train practitioners in the intervention; it must also engage participating organizations to ensure that the program is supported.

Use Community Surveillance Monitoring to Track Population-Level Outcomes

Evidence concerning the impact of public health interventions focuses on the well-being of entire populations of children and parents. This focus requires some form of population-level auditing, community surveillance, or surveying of parents to assess whether parental concerns about children's behavioral and emotional problems have decreased and whether there has been an increase in parent use of positive parenting methods and a decrease in dysfunctional parenting practices. Participation rates in parenting programs and access to formal and informal support should increase.

The types of measures used in a population trial are less well developed than are the measures used for efficacy or effectiveness trials (Prinz & Sanders, 2007). We have used population-level household surveys collected through CATIs, which have included assessment of constructs that provide population indices of penetration and impact, assessment of practitioners, and evaluation of cost considerations. Prinz and Sanders (2007) employed aggregate archival data at a county level to evaluate the impact of Triple P as a population-level intervention to prevent child maltreatment. The data came from records of statutory authorities that assessed founded and unfounded cases of child mal-

treatment, out-of-home placements, and hospitalization accident and injury data.

Development, Implementation, and Quality Assurance Issues

Design of Resources

A public health intervention requires a range of high-quality practitioner and parent resources. We have sought to apply the concept of self-regulation to the development of these resources. The type of parent resources used depends on the level of intervention, the type of delivery modality, and the resource's original use. Where possible, the information included in parenting materials depicts solutions or strategies that have been subjected to empirical evaluation. In the absence of definitive trials, materials were developed on the basis of evidence-based principles and strategies that have been shown to work for similar problems. Where evidence is available for different strategies, those different options are presented.

The principle of sufficiency means that minimally sufficient information (just enough) is used to solve a problem. For example, although a large number of tip sheets that deal with specific developmental issues or behavioral problems, workbooks, and DVDs are part of the Triple P system, we advocate using only those resources that are actually needed to resolve a problem. Achieving a good outcome depends on providing clear, understandable parenting information with enough detail so the parent can decide whether the depicted strategy is acceptable, can follow the suggested solution, and can generalize the strategy to other situations. Giving a parent more information than he or she requires is just as problematic as providing insufficient information, as it can lead to information overload and redundancy.

Engagement of Families

Although parenting problems occur across the whole spectrum of socioeconomic groups, a public health approach needs to build in engagement strategies to ensure that those who require assistance the most actually receive it. Disadvantaged parents living in poverty, recent immigrants, and indigenous parents need additional efforts to engage them in parenting programs (Sanders & Bor, 2007).

Program design strategies to improve engagement include offering tailored versions of the programs for specific high-need groups (e.g., parents of a child with a disability, maltreating parents). Observational documentary and lifestyle television programs that deliver parenting messages through the mass media have been shown to be effective in changing parenting practices (e.g., Sanders, Montgomery, & Brechman-Toussaint, 2000). The workplace has been used effectively as a context to deliver Triple P seminars and groups (Martin & Sanders, 2003). Heinrichs (2006) found that a small financial payment for high-risk, low-income parents for session attendance increased participation rates among German parents.

Program Fidelity

Maintenance of program fidelity can be extremely difficult if professionals work in isolation, and there is no workplace culture to support evidence-based interventions. Program drift can occur unless program adherence is supported by an organization's leadership, so that a workplace culture built around evidence-based practice is given more than lip service. Other threats to effective implementation include difficulty in accessing necessary program resources, defunding of a program, and change in policy that gives lower priority to prevention and early intervention services for children. Strategies to minimize the extent of this drift include surveying practitioners to identify aids and barriers to program implementation, developing a survey for program managers to assess organizational readiness to support an evidence-based program, and providing ongoing technical advice and support to agencies that implement the program.

Commitment to Research

As a form of behavioral family intervention, the Triple P model evolved within a scientific tradition that valued rigorous evaluation of outcomes and pursuit of greater understanding about what intervention works for whom and under what circumstances. Ensuring that the program has an adequate evidence base that demonstrates efficacy and effectiveness has meant that all aspects of the intervention system—including different levels of intervention, modes of delivery, and programs targeting specific problems and age groups—must be subjected to empirical scrutiny. This scientific agenda is necessary to ensure that the program continues to evolve in the light of new evidence. To assist with this task, an international network of researchers in Australasia, North America, Asia, and Europe has been formed to promote scientific inquiry into all aspects of the program and its dissemination. This networking has led to independent replications and a series of international collaborations that contribute to the growing body of evidence concerning the intervention. Examples of such trials include such collaborations as the large-scale population trial of the Triple P system conducted in South Carolina (Prinz & Sanders, 2007) and Germany (e.g., Heinrichs et al., 2006). An international scientific advisory committee, the annual Helping Families Change Conference, and an electronic newsletter are used to promote the dissemination of scientific findings and interaction between researchers and practitioners around the world.

The Sociopolitical Environment

Broader Sociopolitical Context

The implementation of a public health model takes time to become properly embedded within a community. This implementation occurs in a broader sociopolitical environment. One concern is the availability of political support and advocacy that transcends political party allegiance, government entities, and other policy-related institutions. A public

health intervention is always vulnerable to changes of government or leadership within funding agencies. Consequently, program advocates who are prepared to publicly support a program need to be nurtured. Other concerns include the availability of recurrent funding, which will ensure that a program can become embedded within an institution and can be sustained over time; social marketing and community advocacy strategies that link parents to the information and support strategies in ways that meet family needs and provide the most intensive levels of support without overwhelming services; strong consumer advocates; and a public relations strategy designed to communicate to government, service providers, and the public about the progression of an initiative.

Challenges Arising From the Differing Perspectives of Stakeholders

Although many different stakeholders need to come together for the benefit of children, occasional misunderstandings are inevitable due to the differing perspectives and priorities of funders, disseminators, researchers, service providers, and parents (consumers). Understanding the broader motivational contexts within which each stakeholder operates can help to promote mutuality of respect and teamwork and a willingness to meet agreed obligations, particularly those relating to participation in evaluation.

A Multidisciplinary Workforce and "Turf Wars"

In a public health intervention, programmers usually seek to make parenting interventions as broadly accessible as possible. One way to do this is to involve service providers from many disciplines. The Triple P System Population Trial in South Carolina, for example, has been training psychologists, social workers, parent educators, preschool directors, nurses, physicians, counselors, and others in the delivery of Triple P (Prinz et al., 2007). This strategy ensures that many families have access to programming and that no discipline can monopolize the program. It is based on the assumption that agencies and organizations promote, or at least do not interfere with, broad participation across disciplines.

Service providers, agency administrators, and program disseminators have the collective professional responsibility to overcome barriers that interfere with client access to needed assistance. "Turf wars" take at least two forms. The more common definition of territoriality is when one agency maintains that certain services or families are that agency's sole province. The more troubling form is when an agency denies services to specific families by claiming that the service or family is not its responsibility. This type of turf war is probably driven by an agency's financial exigencies, but the consequence is that families might not receive the services they need. Strategies that promote better understanding of the respective and complementary roles of different disciplines and organizations can improve access to services for families in need of support (e.g., across agencies and multidisciplinary-based training).

Program Utilization

The public health approach to parenting services is a relatively new but very promising approach. However, the public health approach is likely to fail if insufficient numbers of trained service providers become regular program users or if, as a consequence, insufficient numbers of parents participate. Provider utilization of Triple P has been shown to be related to whether the provider completes the full training process, including accreditation (Seng, Prinz, & Sanders, 2006). Other factors are the practitioner's self-efficacy following training and the level of organizational support the provider receives (Turner, Nicholson, & Sanders, 2007).

We have employed a number of strategies to promote continued program use following initial training. These include establishment of a Web-based support network for service providers (www.triplep.net and www.triplep.org), assignment of dissemination staff to provide technical support, promotion of peer supervision groups, use of briefing days that enable line managers to better support staff in their organization, and development of Web tools for easier, more convenient program use.

Challenges Ahead

Is the Public Health Approach Really Cost Effective?

Parenting programs reach only a small percentage of the parenting population (Sanders et al., 2007). To change this situation, research on the economic value of parenting programs will be important. Such research has been undertaken to examine the economic implications of the Triple P approach to parenting. Foster, Prinz, Sanders, and Shapiro (2008) assessed the costs of establishing a public health infrastructure in the United States to support the implementation of Triple P in nine counties in South Carolina. The costs of building the necessary infrastructure were quite modest and were less than $12 per child. For a relatively modest investment, the core infrastructure was created to implement an evidence-based, public health intervention. Given the extremely high societal costs of child and family problems, such an investment is likely to be cost effective.

In 2007, Mihalopoulos, Sanders, Turner, Murphy-Brennan, and Carter conducted a threshold analysis and estimated the level of reduction in cases of conduct disorder expected from implementation of the Triple P system, plus the associated cost savings. This analysis showed that the Triple P system would pay for itself if it averted less than 1.5% of cases of conduct disorder. With greater levels of effectiveness, Triple P would cost less than the amount of government expenditure it saves.

Not an Inoculation Model

Confining parenting services to a single developmental period in the hope that, like vaccination, they will have a long-term protective function is unlikely to be effective in

preventing future problems with children. Although there is greater developmental plasticity in the first 3 years of children's development, the mobility of parents, unforeseen circumstances that families encounter (e.g., loss, death of a family member, separation and divorce, dislocation, change in employment status), and the changing developmental needs of children mean that parenting programs need to be continuously accessible throughout a parent's parenting career. However, if early parenting interventions are successful, later programs may not need to be as intensive. Booster sessions may be effective for some parents but not for others.

A Cautionary Note

Raising children is a complex and demanding task, and parents will likely experience a certain level of anxiety or apprehension about their role. As a consequence, guidance and support from professionals are likely to be valued resources for parents at some stage of their development. The mushrooming parent education industry, with its proliferation of commercial and government-sponsored websites and reality parenting programs, has popularized parenting education to the point where it can be very difficult for parents to differentiate between professional advice, homespun theory, and pop psychology. As consumers, parents should be better informed about the kind of advice and support they can reasonably expect from professionals. Well-informed parents will create consumer-driven pressure on government services and agencies to deliver quality evidence-based programs in ways that are cost efficient and convenient for parents to receive.

Conclusion

The development of an effective public health model of parenting support takes the sustained effort and support of many people. All children have a right to good parenting. The adverse living circumstances of some parents, the challenge of managing work and family responsibilities, and the presence of economic worries of many families mean that no single program can meet the needs of all parents. We have sought to identify the gaps in existing parenting services and to develop a suite of evidence-based programs that increase the accessibility of support for the population of parents in a community.

References

Ash, J. (1997). Organizational factors that influence information technology diffusion in academic health science centers. *Journal of the American Information Association, 4,* 102–111.

Azar, S. T., & Rohrbeck, C. A. (1986). Child abuse and unrealistic expectations: Further validation of the Parent Opinion Questionnaire. *Journal of Consulting and Clinical Psychology, 54,* 867–868.

Backer, T. E., Liberman, R. P., & Kuehnel, T. G. (1986). Dissemination and adoption of innovative psychosocial interventions. *Journal of Consulting and Clinical Psychology, 54,* 111–118.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84,* 191–215.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice-Hall.

Biglan, A. (1995). Translating what we know about the context of antisocial behavior into a lower prevalence of such behaviour. *Journal of Applied Behavior Analysis, 28*(4), 479–492.

Biglan, A., Mrazek, P. J., & Carnine, D. (1999). *Strategies for translating research into practice.* Unpublished manuscript.

Bodenmann, G., Cina, A., Ledermann, T., & Sanders, M. R. (2008). The efficacy of Positive Parenting Program (Triple P) in improving parenting and child behavior: A comparison with two other treatment conditions. *Behaviour Research and Therapy, 46,* 411–427.

Coie, J. D. (1996). Prevention of violence and antisocial behavior. In R. D. Peters & R. J. McMahon (Eds.), *Banff International Behavioral Science Series: Vol. 3. Preventing childhood disorders, substance abuse, and delinquency* (pp. 1–18). Thousand Oaks, CA: Sage.

Collins, W. A., Maccoby, E. E., Steinberg, L., Hetherington, E. M., & Bornstein, M. H. (2000). Contemporary research on parenting: The case for nature and nurture. *American Psychologist, 55,* 218–232.

Connell, S., Sanders, M. R., & Markie-Dadds, C. (1997). Self-directed behavioral family intervention for parents of oppositional children in rural and remote areas. *Behavior Modification, 21,* 379–408.

Farquhar, J. W., Fortmann, S. P., Maccoby, N., Haskell, W. L., Williams, P. T, Flora, J. A., et al. (1985). The Stanford Five-City Project: Design and methods. *American Journal of Epidemiology, 122*(2), 323–334.

Flay, B. R., Biglan, A., Boruch, R. F., Castro, F. G., Gottfredson, D., Kellam, S., et al. (2005). Standards of evidence: Criteria for efficacy, effectiveness and dissemination. *Prevention Science, 6*(3), 151–175.

Foster, E. M., Prinz, R. J., Sanders, M. R., & Shapiro, C. J. (2008). The cost of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review, 30,* 493–501.

Heinrichs, N. (2006). The effects of two different incentives on recruitment rates of families into a prevention program. *Journal of Primary Prevention, 27,* 345–366.

Heinrichs, N., Hahlweg, K., Bertram, H., Kuschel, A., Naumann, S., & Harstick, S. (2006). Die langfristige Wirksamkeit eines Elterntrainings zur universellen Prävention kindlicher Verhaltensstörungen: Ergebnisse aus Sicht der Mütter und Väter [The long-term efficacy of a parent training for universal prevention of child behavior problems: Results from the mother's and father's perspective]. *Zeitschrift für Klinische Psychologie und Psychotherapie, 35,* 97–108.

Henggeler, S. C., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystematic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology, 65,* 821–833.

Karoly, P. (1993). Mechanisms of self-regulation: A systems view. *Annual Review of Psychology, 44,* 23–52.

Leung, C., Sanders, M. R., Leung, S., Mak, R., & Lau, J. (2003). An outcome evaluation of the implementation of the Triple P-Positive Parenting Program in Hong Kong. *Family Process, 42*(4), 95–108.

Loeber, R., & Farrington, D. P. (1998). Never too early, never too late: Risk factors and successful interventions for serious and

violent juvenile offenders. *Studies on Crime & Crime Prevention, 7,* 7–30.

Markie-Dadds, C., & Sanders, M. R. (2006). Self-directed Triple P (Positive Parenting Program) for mothers with children at-risk of developing conduct problems. *Behavioural and Cognitive Psychotherapy, 34*(3), 259–275.

Martin, A. J., & Sanders, M. R. (2003). Balancing work and family: A controlled evaluation of the Triple P-Positive Parenting Program as a work-site intervention. *Child and Adolescent Mental Health, 8*(4), 161–169.

Matsumoto, Y., Sofronoff, K., & Sanders, M. R. (2007). The efficacy of the Triple P-Positive Parenting Program with Japanese parents. *Behaviour Change, 24,* 205–218.

Mihalopoulos, C., Sanders, M. R., Turner, K. M. T., Murphy-Brennan, M., & Carter, R. (2007). Does the Triple P-Positive Parenting Program provide value for money? *Australian and New Zealand Journal of Psychiatry, 41*(3), 239–246.

Morawska, A., & Sanders, M. R. (2006). Self-administered behavioral family intervention for parents of toddlers: Part I. Efficacy. *Journal of Clinical and Consulting Psychology, 74*(1), 10–19.

Parcel, G. S., Perry, C. L., & Taylor, W. C. (1990). Beyond demonstration: Diffusion of health promotion innovations. In N. Bracht (Ed.), *Sage sourcebooks for the human services: Vol. 15. Health promotion at the community level* (pp. 229–251). Thousand Oaks, CA: Sage.

Patterson, G. R. (1982). *Coercive family process.* Eugene, OR: Castalia Press.

Peterson, L., & Saldana, L. (1996). Accelerating children's risk for injury: Mothers' decisions regarding common safety rules. *Journal of Behavioral Medicine, 19*(4), 317–331.

Prinz, R. J., & Sanders, M. R. (2007). Adopting a population level approach to parenting and family support interventions. *Clinical Psychology Review, 27,* 739–749.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2007). *Population-based prevention of child maltreatment: The U.S. Triple P system population trial.* Manuscript submitted for publication.

Risley, T. R., Clark, H. B., & Cataldo, M. F. (1976). Behavioral technology for the normal middle-class family. In E. J. Mash, L. A. Hamerlynck, & L. C. Handy (Eds.), *Behavior modification and families* (pp. 34–60). New York: Brunner/Mazel.

Sanders, M. R. (1999). The Triple P-Positive parenting program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review, 2*(2), 71–90.

Sanders, M. R., & Bor, W. (2007). Working with families in poverty: Toward a multilevel, population-based approach. In D. R. Crane & T. B. Heaton (Eds.), *Handbook of families and poverty: Interdisciplinary perspectives* (pp. 442–456). New York: Wiley.

Sanders, M. R., Calam, R., Durand, M., Liversidge, T., & Carmont, S. (in press). Does self-directed and web-based support for parents enhance the effects of viewing a reality television series based on the Triple P-Positive Parenting Program? *Journal of Child Psychology and Psychiatry.*

Sanders, M. R., Cann, W., & Markie-Dadds, C. (2003). The Triple P-Positive Parenting Program: A universal population-level approach to the prevention of child abuse. *Child Abuse Review, 12*(3), 155–171.

Sanders, M. R., & Glynn, E. L. (1981). Training parents in behavioral self-management: An analysis of generalization and maintenance effects. *Journal of Applied Behavior Analysis, 14*(3), 223–237.

Sanders, M. R., Markie-Dadds, C., Rinaldis, M., Firman, D., & Baig, N. (2007). Using household survey data to inform policy decisions regarding the delivery of evidence-based parenting interventions. *Child: Care, Health and Development, 33,* 768–783.

Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2003). Theoretical, scientific and clinical foundations of the Triple P–Positive Parenting Program: A population approach to the promotion of parenting competence. *Parenting Research and Practice Monograph*(1), 1–21.

Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68,* 624–640.

Sanders, M. R., Mazzucchelli, T. G., & Studman, L. (2004). Stepping Stones Triple P: The theoretical basis and development of an evidence-based positive parenting program for families with a child who has a disability. *Journal of Intellectual and Developmental Disability, 29,* 265–283.

Sanders, M. R., Montgomery, D., & Brechman-Toussaint, M. (2000). The mass media and the prevention of child behavior problems: The evaluation of a television series to promote positive outcomes for parents and their children. *Journal of Child Psychology and Psychiatry, 41*(7), 939–948.

Sanders, M. R., Pidgeon, A., Gravestock, F., Connors, M. D., Brown, S., & Young, R. (2004). Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? *Behavior Therapy, 35*(3), 513–535.

Sanders, M. R., & Prinz, R. J. (in press). Public health approaches to parenting: Ethical and professional issues in the implementation of population-level parenting interventions. *Clinical Psychology: Science and Practice.*

Sanders, M. R., Ralph, A., Thompson, R., Sofronoff, K., Gardiner, P., Bidwell, K., & Dwyer, S. (2005). *Every Family: A public health approach to promoting children's well-being.* Brisbane, Australia: University of Queensland.

Sanders, M. R., & Turner, K. M. T. (2002). The role of the media and primary care in the dissemination of evidence-based parenting and family support interventions. *Behavior Therapist, 25,* 156–166.

Sanders, M. R., & Turner, K. M. T. (2005). Reflections on the challenges of effective dissemination of behavioural family intervention: Our experience with the Triple P-Positive Parenting Program. *Child and Adolescent Mental Health, 10*(4), 158–169.

Sanders, M. R., & Woolley, M. L. (2005). The relationship between global, domain, and task-specific self-efficacy and parenting practices: Implications for parent training. *Child: Care, Health and Development, 31*(1), 65–73.

Sawyer, M. G., Arney, F. M., Baghurst, P. A., Clark, J. J., Graetz, B. W., Kosky, R. J., et al. (2000). *The mental health of young people in Australia.* Canberra, Australia: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

Seng, A. C., Prinz, R. J., & Sanders, M. R. (2006). The role of training variables in effective dissemination of evidence-based parenting interventions. *International Journal of Mental Health Promotion, 8*(4), 19–27.

Serketich, W. J., & Dumas, J. E. (1996). The effectiveness of behavioural parent training to modify antisocial behaviour in children: A meta-analysis. *Behaviour Therapy, 27,* 171–186.

Taylor, T. K., & Biglan, A. (1998). Behavioral family interventions for improving child rearing: A review of the literature for

clinicians and policy makers. *Clinical Child and Family Psychology Review, 1,* 41–60.

Turner, K. M. T., Nicholson, J. M., & Sanders, M. R. (2007). *The role of practitioner self-efficacy, training, program and workplace factors on the implementation of an evidence-based parenting intervention in primary care.* Manuscript submitted for publication.

Turner, K. M. T., & Sanders, M. R. (2006a). Help when it's needed first: A controlled evaluation of brief, preventive behavioral family intervention in a primary care setting. *Behavior Therapy, 37*(2), 131–142.

Turner, K. M. T., & Sanders, M. R. (2006b). Dissemination of an evidence-based, population-level parenting and family support strategy: Our experience with the Triple P-Positive Parenting Program. *Aggression and Violent Behavior, 11*(2), 176–193.

Venning, H. B., Blampied, N. M., & France, K. G. (2003). Effectiveness of a standard parenting-skills program in reducing stealing and lying in two boys. *Child and Family Behavior Therapy, 25,* 31–44.

Zubrick, S. R., Ward, K. A., Silburn, S. R., Lawrence, D., Williams, A. A., Blair, E., et al. (2005). Prevention of child behavior problems through universal implementation of a group behavioural family intervention. *Prevention Science, 6*(4), 287–304.